4440. HOME AND COMMUNITY-BASED SERVICES - BASIS, SCOPE, AND PURPOSE

A. Legislation.--Section 1915(c) of the Act authorizes the Secretary of Health and Human Services (HHS) to waive certain Medicaid statutory requirements to enable you to cover a broad array of home and community-based services as an alternative to institutionalization. This provision was added to the statute as part of P.L. 97-35, OBRA 1981 and amended by P.L. 99-272, COBRA 1985, P.L. 99-509, OBRA 1986, P.L. 100-203, OBRA 1987, P.L. 100-360, the Medicare Catastrophic Coverage Act of 1988, P.L. 100-647, the Technical and Miscellaneous Revenue Act and P.L. 101-508, OBRA 1990. Prior to P.L. 97-35, the Medicaid program provided little coverage for long term care services in a noninstitutional setting, but offered full or partial coverage for such care in an institution. In an effort to address these concerns, §2176 of P. L. 97-35 was enacted, adding §1915(c) to the Act. A home and community-based services waiver offers you broad discretion not generally afforded under the State plan to address the needs of individuals who would otherwise receive costly institutional care provided under the State Medicaid plan.

Additionally, the law specifically provides that a home and community-based services waiver may include a waiver of the statewideness and comparability requirements of §1902(a)(1) and (10)(B) of the Act. Under §1902(a)(1) of the Act, a State plan for medical assistance must be in effect throughout the State. Section 1902(a)(10)(B) requires the plan to provide comparable services (in amount, duration and scope) to all categorically needy individuals and to each covered medically needy group and also requires that the services available to the categorically needy not be less in amount, duration and scope than those available to medically needy beneficiaries. Under a waiver of these statewideness and comparability requirements, home and community-based services do not have to be provided throughout the State. You may target home and community-based services to a limited, select group of eligibles, such as the developmentally disabled. You are not required to provide the services to all eligible individuals who require a hospital (see NOTE), NF or ICF/MR level of care. Under the waiver, you may also exclude those individuals for whom there is a reasonable expectation that home and community-based services would be more expensive than the Medicaid services the individual would otherwise receive in an institution.

Lastly, §1902(a)(10)(A)(ii)(VI) of the Act authorizes optional categorical eligibility to individuals who would be eligible under the State plan if they were in a medical institution and who would require the level of care provided in a hospital, NF or ICF/MR but for the provision of home and community-based services described in §1915(c) of the Act, the cost of which could be reimbursed under the State plan. This may include (depending on the State plan), but is not limited to, individuals who would be eligible for Medicaid in an institution because income from parents or a spouse is not deemed available to them, and individuals who would be eligible for Medicaid under a special income level if they were institutionalized. (See 42 CFR 435.217 and 42 CFR 435.236.)

NOTE: Under P.L. 99-509, individuals may participate in a waiver if they require a hospital, NF or ICF/MR level of care. This provision applies to applications for waivers (or renewals thereof) approved on or after October 21, 1986.

B. Regulations.--HCFA published a final rule with comment period in the Federal Register on July 25, 1994. This final rule expands coverage of Medicaid home and community-based services under §1915(c) of the Social Security Act and responds to public comments that were received as a result of the June 1, 1988 publication of a proposed rule. These regulations were codified at 42 CFR 440.180 (Subpart A), 42 CFR 440.250 (Subpart B), and 42 CFR 441.300 through 441.310 (Subpart G).

4441. HOME AND COMMUNITY-BASED SERVICES - PROCESS

A. Applicability.--The process applies to initial requests for a home and community-based services waiver (including general waiver requests described in §4442 and model waiver requests described in §4443), to requests for renewals described in §4444, and to requests for amendments to approved waivers described in §4445, except as may be otherwise specified in those sections.

B. Submission.--Send your request for a home and community-based services waiver under §1915(c) of the Act to:

Health Care Financing Administration
Medicaid Bureau
C4-13-01
7500 Security Boulevard
Baltimore, MD 21244-1850

Submit an original and two copies of the request. Attach a copy of all required information and documentation to each copy of the request. Also send one copy of the letter and all attachments to your HCFA RO. In the letter of request, include the name and telephone number of an individual who may be contacted with specific technical questions on the request.

C. Timeframes.--The law specifies that the Secretary must approve or deny a request for a §1915(c) waiver, or request additional information, by the 90th day after receipt or the waiver request will be deemed approved. The date of receipt is the earliest date the request is received by the HCFA official to whom it is addressed.

While the Department may take the full 90 days to render a decision, HCFA's analysis of the waiver request and preparation of a recommendation for action must generally be completed by the 60th day after receipt. It is imperative that you respond to informal (i.e., unwritten) requests for additional information as soon as possible, since such requests do not stop the clock.

D. Additional Information.--If HCFA has concerns regarding an initial waiver request or amendment proposal which are significant enough to prevent approval, but there is a reasonable expectation that the problems can be resolved, HCFA may make a formal request in writing for additional information. When HCFA issues a formal request, this stops the 90-day approval period that began with receipt of the State's original waiver submission. When the response is received, HCFA again has a new 90-day period to approve or deny the request beginning with the date HCFA receives your response. No further formal request may be made unless you withdraw the waiver and submit a revised waiver request.

HCFA may, however, request informal additional information through meetings or telephone contact. Such request cannot stop the clock and as such is usually made only when the needed information is expected to resolve the problems preventing approval. Because informal requests do not stop the clock, it is important that your response be provided to HCFA as soon as possible. The use of same-day or overnight private delivery services is appropriate in many cases.

E. Effective Date.--The effective date of a new waiver will be established by HCFA in consultation with you but may be no earlier than the date of HCFA's approval action. This also applies to a renewal request that HCFA has determined is a new waiver request and not a renewal request. Therefore, it is suggested that you plan your new proposal with effective dates at the beginning of a calendar quarter at least 90 but not more than 180 days after receipt of the proposal by HCFA. Moreover, it is also suggested that the effective date be the first day of the month or of the calendar quarter to facilitate the reporting of data on the waiver.

Because the effective date of a new request will depend on the date approved, any formal request for additional information will likely necessitate a revised effective date. An initial approved waiver continues for a 3-year period from the effective date and may be renewed. (See §4444.)

F. Review of Waiver Request.--Requests for new Medicaid home and community-based services waivers are reviewed by several different components of HCFA CO with respect to each component's area of specialty. Moreover, the appropriate HCFA RO also reviews each new request and provides comments for use in developing a recommendation for action. As of October 1, 1993, HCFA ROs have lead responsibility for waiver renewals and amendments to renewed waivers.

4442. WAIVER REQUEST REQUIREMENTS

In order to provide home and community-based services (not available under your State plan) to individuals who would otherwise require institutionalization, any request (except a model request as detailed in §4443) for a §1915(c) waiver must address all of the requirements of §§4442.1-4442.11.

4442.1 Scope of Waivers Requested.--Home and community-based services waivers under §1915(c) of the Act allow FFP to be available for a number of services, including those services outside the State Medicaid plan which are not included in the definition of "medical assistance" in §1905(a) of the Act. However, it must be demonstrated that the provision of such services will enable you to serve recipients at a cost which is not more than the cost of serving such individuals in a hospital, NF, or ICF/MR (whose costs would otherwise be reimbursed under your State plan). The services proposed to be provided in the waiver must not duplicate services which are provided under your State Medicaid plan. However, you may provide services under a waiver similar to those provided under the State plan where they are defined differently under the waiver or where they differ in amount, duration, or scope from those provided in the State plan.

If you do not intend to offer the services under the waiver to all individuals who qualify for medical assistance, include a request for waiver of §1902(a)(1) or §1902(a)(10)(B), or both as appropriate. A waiver of §1902(a)(10)(B) is a necessary component of all waiver proposals. If a waiver is requested of "statewideness" (§1902(a)(1)), inform HCFA of the political subdivisions in which waivered services will be offered.

Section 4118 of OBRA-87 provided a technical amendment to specifically provide in §1915(c)(3) of the Social Security Act for a waiver of §1902(a)(10)(C)(i)(III) to allow for the use of institutional deeming rules for the medically needy. Reinstatement of this waiver is retroactive to waivers or renewals approved on or after October 21, 1986.

Application of institutional deeming rules means that income and resources are not deemed to the recipient from a spouse or parent; thus making an individual eligible for Medicaid who might not otherwise qualify. This allows you to cover under home and community-based services waivers medically needy individuals who would not be eligible for waiver services under the community rules, but would be eligible under institutional rules.

You may wish to request a waiver of §1902(a)(10)(C)(i)(III) to allow for the use of institutional deeming rules for the medically needy population.

If you intend to limit in any way the recipient's freedom of choice to participate in the waiver or to choose the provider(s) of service, apply separately to HCFA for a waiver of the freedom of choice provisions authorized under §1915(b) of the Act. Section 2100 describes the procedures for this application. Otherwise, the requirements of §4442.7 must be met.

4442.2 Description of Waiver Participants.--Describe in the waiver request who is eligible to receive the waivered services. Indicate the Medicaid groups (e.g., categorically needy, optional categorically needy or medically needy) to be eligible under the waiver plus any additional targeting criteria that will be applied, e.g., elderly, mentally retarded. For an eligibility group to be included under the waiver, the eligibility group must be included under the State plan. The waiver request must satisfy the following eligibility requirements:

A. Indicate if you wish to include the optional categorically needy eligibility group authorized under §1902(a)(10)(A)(ii)(VI) of the Act (individuals who would be eligible for Medicaid if they were in an institution, who have been determined to need home and community-based waiver services in order to remain in the community, and who are covered under the terms of the waiver) in this waiver and specify which eligibility group or groups you are including under this authority in this waiver.

B. All home and community-based waiver recipients found eligible under 42 CFR 435.217, are subject to post-eligibility calculations. Explain how the applicable provisions will be applied (see 42 CFR 435.726 and 42 CFR 435.735 and §1924 of the Act) regarding post-eligibility treatment of income and resources of those receiving home and community-based services who are eligible under the special home and community-based waiver eligibility group (specified in 42 CFR 435.217). Include the amounts of income to be protected for a beneficiary, spouse, and family and incurred medical expenses not subject to copayment by a third party. (This requirement is applicable only to individuals eligible under the special home and community-based waiver eligibility group.)

Section 9502(e) of COBRA and §9435(a) of OBRA-86, which apply to waivers or waiver renewals approved before, on, or after April 7, 1986, provide that you may set your own maintenance needs deduction amounts for individuals without regard to the limits imposed by regulations at 42 CFR 435.726(c)(1) and 42 CFR 435.735(c)(1). Establish a maximum maintenance needs deduction amount which will not be exceeded for any individual under the waiver, and the maintenance

needs deduction amount must be based on a reasonable assessment of the individual's needs. Except for those restrictions, you may establish the deduction amount for individuals at any level you choose. You may also establish different deduction amounts for different individuals, or groups of individuals, based on an assessment of each individual's or group's particular needs.

The upper limits for maintenance needs deduction amounts already established in regulations for spouses and dependent children continue to apply. However, as with the deduction amount for individuals described above, you may establish the deduction amount for a spouse or dependent children based on an assessment of each spouse's or family's needs. (See §3590.9.)

Pending publication of final regulations, spousal impoverishment eligibility rules, specified at §1924 of the Act, may be used for individuals with a community spouse (whose eligibility is determined under 42 CFR 435.217).

States have an option concerning the application of the post-eligibility rules for individuals with a community spouse. States may use the spousal impoverishment post-eligibility rules specified at §1924 of the Act or the post-eligibility rules specified at 42 CFR 435.726 and 435.735. (Spousal impoverishment post-eligibility rules can be used only if the State is using spousal impoverishment eligibility rules.)

The spousal impoverishment post-eligibility rules provide for a more generous community spouse and family allowance than the rules under 42 CFR 435.726 and 42 CFR 435.735. The spousal protection rules also provide for a personal needs allowance (PNA) described in §1902(q)(1) of the Act for the needs of the institutionalized individual. This allowance is a "reasonable amount for clothes and other personal needs of the individual...while in an institution." For an institutionalized individual, this can be as low as $30 per month. Unlike the institutionalized individual whose room and board is being covered under Medicaid, the personal needs of the home and community-based waiver recipient must include a reasonable amount for food and shelter as well as for clothing. The $30 monthly PNA is not a sufficient amount for these needs when the individual is living in the community.

Therefore, States which elect to treat home and community-based services waiver participants with community spouses under the §1924 spousal rules must use as the personal needs allowance either the maintenance amount which the State has elected under 42 CFR 435.726 or 42 CFR 435.735, or an amount that the State can demonstrate is a reasonable amount to cover the individual's maintenance needs in the community.

C. Indicate that services will only be furnished to those eligible beneficiaries who, but for this provision, would require the level of care provided in a hospital, NF, or ICF/MR.

D. Indicate that home and community-based services will not be provided to recipients who are inpatients of a hospital, NF, or ICF/MR.

E. Indicate if you accept the option not to offer home and community-based services to individual beneficiaries on the basis that you can reasonably expect that the services would cost more than institutional services.

F. Be limited to one of the following target groups or any subgroup thereof:

- o Aged or disabled, or both;
- o Mentally retarded or developmentally disabled, or both; or
- o Mentally ill.

4442.3 Definition of Services.--"Home and community-based services" means services that are furnished under a waiver granted under the provisions of Part 441, Subpart G of 42 CFR. The services may consist of any of the following services, as defined by the agency, that meet the standards specified in §4442.4:

- o Case management services;
- o Homemaker services;
- o Personal care services;
- o Adult day health services;
- o Habilitation services;
- o Respite care services;
- o Day treatment or other partial hospitalization services, psychosocial rehabilitation services and clinic services (whether or not furnished in a facility) for individuals with chronic mental illness; and
- o Other services requested by the Medicaid agency and approved by HCFA as cost effective and necessary to avoid institutionalization.

A. General.--

1. Specify which services will be provided under the waiver, and define each service. Provide at least one of the services listed in §4442.3.

2. The definition of each service must be exhaustive (e.g., a detailed list of each item of medical equipment that may be provided) or closed-ended (i.e., "only those medical supplies needed for the respirator-related needs of a respirator-dependent patient"). The definition may not include such phrases as "including but not limited to . . .," "for example . . .," "including . . .," etc.

3. No service may be provided under the waiver if it is already provided under the State plan unless the nature or the amount of the service, when provided under the waiver, would not be covered if provided under the State plan. For example, if the waiver provides for the coverage of home health aide services, the maximum number of visits allowed under the waiver could be greater than the limit contained under the State plan. The amount chargeable for waiver services is that amount incurred after any limits in State plan services have been reached. Similarly, if the State

proposed to provide home health aide services which were defined more broadly than those available under the State plan, these could be included as waiver services.

4. Define each specific service separately. Multiple services commonly considered separate services (e.g., personal care and habilitation services) generally may not be packaged as a single "comprehensive" service to which one expansive definition is applicable. Further, each definition must be reasonably related to the common meaning(s) of the service defined. A combined service definition (bundling) will be considered if you establish that the bundling of services will permit more efficient delivery of services and not compromise either an individual's access to services or free choice of providers. (See §4442.8C.2.d.)

5. Assure HCFA that each "other" service, independent of any others, is essential to prevent institutionalization, and provide a reasonable explanation as to why it is essential.

6. Cost out each "other" service, documenting the estimated costs and utilization with actual cost data (e.g., from studies or current price lists), and demonstrate the cost effectiveness of each. This documentation must be separate from that provided in your overall cost demonstration using the formula prescribed in 42 CFR 441.303(f).

B. Considerations Related to Specific Services.--

1. FFP is not available for personal care services or any waiver services when provided to recipients by legally responsible relatives, i.e., spouses or parents of minor children, when the services are those that these persons are already legally obligated to provide.

2. Services provided by relatives or friends, except as noted in item B.1., may be covered only if the relatives or friends meet the qualifications for providers of care, there are strict controls to assure that payment is made to the relative or friend as providers only in return for specific services rendered, and there is adequate justification as to why the relative or friend is the provider of care, e.g., lack of other qualified provider in remote areas. Medicaid payment may be made to qualified parents of minor children or to spouses for extraordinary services requiring specialized skills (e.g., skilled nursing, physical therapy) which such people are not already legally obligated to provide.

3. Prevocational, educational or supported employment services may not be provided under the waiver other than as part of habilitation services as defined below.

However, effective on or after April 7, 1986, you may include in your definition of habilitation services furnished to individuals who have been discharged from a NF or ICF/MR prevocational, educational, and supported employment services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully outside an institution. This expanded definition of habilitation applies to individuals who have been discharged from a Medicaid certified NF or ICF/MR, regardless of when the discharge occurred.

a. Prevocational services are services aimed at preparing an individual for paid or unpaid employment but which are not job task oriented. They could include teaching a client such concepts as compliance, attending, task completion, problem solving and safety. They are aimed at a more generalized result. In distinguishing prevocational services coverable under a waiver from noncovered vocational services, consider the following criteria. Prevocational service activities:

o Are provided to persons who are not expected to be able to join the general work force or participate in a transitional sheltered workshop within 1 year (excluding supported employment programs),

o If compensated, are compensated at less than 50 percent of the minimum wage,

o Include activities which are not primarily directed at teaching specific job skills but at underlying habilitative goals (e.g., attention span, motor skills), and

o Are reflected in a plan of care directed to habilitative rather than explicit employment objectives consonant with the aims outlined in the preceding criteria.

b. Educational services are special education and related services (as defined in §4(a)(4) of the 1975 Amendments to the Education of the Handicapped Act) (Public Law 94-142) (20 U.S.C. 140(16) and (17)) to the extent they are not prohibited under §4442.3B3e.

c. Supported employment is paid employment which:

o Is for persons for whom competitive employment at or above the minimum wage is unlikely and who, because of their disabilities, need intensive ongoing support to perform in a work setting;

o Is conducted in a variety of settings, particularly worksites in which persons without disabilities are employed; and

o Is supported by any activity needed to sustain paid work by persons with disabilities, including supervision, training and transportation.

d. Habilitation services do not include special education and related services (as defined in §4(a)(4) of the 1975 Amendments to the Education of the Handicapped Act (20 U.S.C. 1401(16), (17)) which otherwise are available to the individual through a State or local educational agency and vocational rehabilitation services which otherwise are available to the individual through a program funded under §110 of the Rehabilitation Act of 1973. (See 29 U.S.C. 730.)

In this context "otherwise are available" means that coverage would be denied under a waiver, on that basis, only if:

o An individual is determined eligible for the special educational or vocational rehabilitation services offered by other agencies, and

o The individual is actually receiving, or will actually receive, the services under those other programs.

Therefore, when habilitation services which include prevocational, educational and/or supported employment services are furnished under a waiver, you must:

o Describe how you will ensure that prevocational, educational and/or supported employment services will be furnished only to individuals who have been discharged from a Medicaid certified NF or ICF/MR who do not have these services available to them, e.g., use of a trailer code to indicate that a person meets that requirement; and

o Assure HCFA that prevocational, educational and/or supported employment services are not available to individuals who will receive them under the Rehabilitation Act of 1973 or the Education of the Handicapped Act and explain why these services are not available. An example is an individual who has applied for vocational rehabilitation from the State vocational rehabilitation agency but has been rejected because of the protracted length of time that is necessary to achieve meaningful rehabilitation goals.

4. Institutional respite care is defined as overnight care furnished in a Medicaid certified institution (hospital, NF, or ICF/MR), foster home, or community residential facility that meets all relevant State licensure or certification requirements as specified in the waiver. Payment under the waiver for room and board costs as part of respite care can be authorized only for care provided in these facilities. The request must assure that when respite care is provided, payment for other duplicative services under the waiver is precluded (e.g., payment for adult day care when the patient is receiving respite care).

5. Each environmental modification must have a specific adaptive purpose that provides accessibility and safety. Secondly, environmental modifications may not be shown as recurring costs for all recipients in years 2 and 3, or in renewals, when it is clear that only a one time cost is incurred. List environmental modifications exhaustively.

6. Transportation services must be provided by the most cost efficient mode. This is not intended to require competitive bidding but to assure that the mode of transportation selected is the least costly practical option, e.g., van vs. ambulette.

7. There must be either an exhaustive list of medical supplies and equipment to be provided, or a definition which contains a clear limit on the range of such supplies and equipment. Moreover, the costs of supplies must be separately determined from the cost of durable equipment if purchased under the waiver. Equipment costs often do not recur in each waiver year and may not be charged to the program again until the life of the equipment is considered exhausted. Acquire durable equipment by the least costly method (rental vs. purchase) dependent upon its anticipated use.

8. Where you propose to provide care in a residential setting (e.g., assisted living, residential therapeutic foster care), there must be a clear differentiation between waiver services and nonwaiver services (e.g., room and board). There must also be a detailed cost allocation strategy

provided as part of the waiver request to explain how the cost of waiver services in the residential setting will be determined and segregated from ineligible waiver costs.

9. Recreational activities may be covered only to the degree that they are not diversional in nature and are included in a plan of treatment related to a specific therapeutic goal.

10. Services such as patient care training may be provided to individuals other than the recipient (e.g., family or close friends) to the extent that they are necessary to enable the recipient to be cared for outside of an institution.

11. Payment for services provided under a home and community-based waiver must be made directly to the provider of the services. No payment may be made to the recipient or any entity other than the provider of waiver services except as specified below for costs of rent and food attributed to an unrelated, live-in personal caregiver. This does not, of course, rule out payment to an organization which functions as a fiscal intermediary, organized health care delivery system, or a governmental entity under a voluntary reassignment. (See item 16 below.)

12. Except for respite care furnished in a State approved facility that is not private residence (see item 4), FFP is not available for room and board of the recipient as part of a home and community-based service. Board means three meals a day or any other full nutritional regimen. Room means hotel or shelter type expenses including all property related costs such as rental or purchase of real estate and furnishings, maintenance, utilities, and related administrative services.

Section 4741(a) of OBRA 1990 provides that the room and board exclusion does not include an amount established by you to reflect the portion of costs of rent and food attributable to an unrelated personal caregiver who is residing in the same household with an individual who, but for the assistance of such caregiver, would require admission to a hospital, NF, or ICF/MR. Unrelated is defined as someone who is unrelated by blood or marriage to any degree. A personal caregiver provides a covered waiver service (as defined in your waiver package) to meet the recipient's physical, social, or emotional needs (as opposed to services not directly related to the care of the recipient, i.e., housekeeping or chore services). Therefore, when a waiver service is provided by an unrelated, live-in personal caregiver, FFP is available to the waiver recipient for the additional costs he/she may incur for the room and board of such caregiver. Under Medicaid and SSI rules, for payment not to be considered income to the recipient, payment for the portion of the costs of rent and food attributable to an unrelated live-in personal caregiver must be made directly to the Medicaid recipient. You may utilize any reasonable method of apportioning the cost of rent and food, subject to review and approval by HCFA. FFP for live-in caregivers is not available in situations in which the recipient lives in the caregiver's home or a residence owned or leased by the provider of Medicaid services.

This provision does not provide any exceptions to other existing Medicaid requirements resulting in a change in the way an individual's income may be counted in determining Medicaid eligibility or to allow payment to a recipient rather than a provider of service.

13. Case management is commonly understood to be an activity which assists individuals in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational, and other appropriate services, regardless of the funding source for the services to which access is gained. The responsibility for these activities rests with a specific person or organization. Case management services may be used to locate, coordinate, and monitor necessary and appropriate services and may be used to encourage the use of cost effective medical care by referrals to appropriate providers and to discourage over utilization of costly services such as emergency room care for routine procedures. Case management services may also serve to provide necessary coordination with providers of nonmedical services, such as local education agencies or department of vocational rehabilitation, when the services provided by these entities are needed to enable the individual to function at the highest attainable level or to benefit from programs for which he or she might be eligible.

Case management activities are authorized under a number of payment authorities and appropriate payments may be made for such services in the context in which they are provided so long as duplication of funding is avoided. For example:

- Case management may be provided by vendors under §1915(b), (c) or (g) according to the circumstances dictated by one or another of those sections. In such cases, Federal payments are at the FMAP rate.

- Case management may also be an integral and inseparable part of an otherwise covered Medicaid service listed in §1905(a). If so, the FMAP is also the appropriate matching rate since that is the rate that is applied to the services of which case management functions are a part.

- Case management functions may also be performed by employees of the State Medicaid agency, either in general administrative support of the State plan or to administer a waiver under §1915(b). In such cases, the matching rate is that determined under §1903 (i.e., the 50 percent administrative match or, if appropriate, one of the premium match rates).

a. Within the context of home and community-based waiver services, case management may include (but is not limited to) the following functions:

- Evaluation and/or reevaluation of level of care,
- Assessment and/or reassessment of the need for waiver services,
- Development and/or review of the plan of care,
- Coordination of multiple services and/or providers,
- Monitoring of quality of care,
- Review of medical necessity of waiver services, and
- Determination of cost effectiveness or waiver services for an individual.

When you request case management as a home and community-based service, specify the functions which comprise the service.

b. Claim case management as a service cost at your FMAP rate:

(1) For those functions included in the definition of a case management service as approved in a home and community-based waiver, regardless of who performs the functions which comprise them (e.g., State employees, the State's contractor, waiver provider, or any other entity),

(2) When furnished by a provider of waiver services (or State plan services) as an integral and inseparable part of another covered Medicaid waiver or State plan service. For example, where a home health agency prepares a plan of care for recipients, since the preparation of these plans is required as a part of home health services, separate payment for the case management component is not made but is included in the payment made for the home health services, or such case management activities are reimbursed as covered home health agency services such as skilled nursing, home health aide, or

(3) When provided as optional targeted case management services under §1915(g)(1) as part of an approved Medicaid State plan amendment.

NOTE: When any service is provided as a waiver service, any client services which may precede the patient's eligibility for waiver services cannot be reimbursed unless, and until, the client becomes eligible for waiver services.

c. Where case management is not requested as a home and community-based service, costs attributable to case management functions may be claimed as State administrative costs if the functions are not part of any defined waiver service or State plan service, and otherwise meet the requirements necessary to be considered allowable State administrative costs.

14. FFP is available for day treatment or partial hospitalization services, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility) when provided to individuals who have been diagnosed as being chronically mentally ill. However, these waiver services may be provided only to individuals age 22 through 64 who would not be in an institution for mental diseases (IMD) in the absence of the waiver. In addition, FFP would not be available for these waiver services for individuals under age 22 or over age 64 who, absent the waiver would be placed in an IMD and you have not opted to include the benefits in 42 CFR 440.160 and 42 CFR 440.140 in your State plan.

15. FFP is not available to facilities providing services in residential settings on days when waiver recipients are temporarily absent and are not receiving covered waivered services (sometimes called reserve bed days). Medicaid payment may be made only for waiver services actually provided to an eligible recipient. Since providers incur fixed costs such as rent, staff salaries, insurance, etc., even when a waiver recipient is temporarily absent, you may account for such continuing costs when developing payment rates for these providers. For example, rent is generally paid for a period of 1 month. However, day habilitation services are generally furnished only 5 days per week. You may take the entire month's rental cost into consideration in setting the rate paid for services furnished on the days the recipient is present. Similarly, if data show that a

recipient is served in residential habilitation an average of 325 days per year and the slot is held open when the recipient is on a leave of absence, you may consider the entire yearly cost to the provider when establishing its rate of payment. However, in the rate setting process, it must be assumed that a facility will not have a 100 percent utilization rate every day of the year. Consequently, payment rates are established by dividing the provider's total allowable costs by the number of Medicaid patient days you estimate recipients will actually utilize.

16. A variety of waiver services may be provided by an organized health care delivery system (OHCDS). An OHCDS must provide at least one service directly (utilizing its own employees) and may contract with other qualified providers to furnish other waiver services. When you use an OHCDS, your provider agreement is with the OHCDS. Since it is the system itself which acts as the Medicaid provider, it is not necessary for each subcontractor of an OHCDS to sign a provider agreement with the Medicaid agency. (However, subcontractors must meet the standards under the waiver to provide waiver services for the OHCDS.) When utilizing an OHCDS to provide waiver services, payment is made directly to the OHCDS and the OHCDS reimburses the subcontractors. Waiver providers may not be restricted to participating only through an OHCDS. Such an arrangement must be voluntary.

4442.4 Safeguards - Assurances and Documentation.--Provide the following assurances and supporting documentation:

A. Assurances.--Provide an assurance that necessary safeguards have been taken to protect the health and welfare of the recipients of the services. The safeguards must include:

1. Adequate standards for each type of provider that will provide services under the waiver;

2. That any applicable State licensure or certification requirements are met for services, individuals, or entities furnishing services provided under the waiver; and

3. That all facilities covered by §1616(e) of the Act, in which home and community-based services will be provided, are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.

B. Documentation.--

1. Identify the type of provider who will provide each waiver service and supply HCFA with a legible copy of the health and safety standards applicable to each provider type. When the only provider requirement is licensure or certification, provide only the applicable State or Federal law or regulatory citation. It is not necessary to provide copies of the statutory or regulatory licensure or certification standards. For each service that requires provider standards other than, or in addition to, State or Federal licensure or certification, you must specify the applicable educational, professional, or other standards that you require for each service provider.

2. If waiver services will be provided in facilities covered by §1616(e) of the Act, identify the Keys amendment standards which govern each of these of facilities. It is not necessary to furnish copies of the Keys amendment standards. However, these copies must be readily

available at the Medicaid agency to be provided to HCFA upon request. Although you must provide the assurance cited above regardless of whether services will be provided in such facilities, if no waiver services will be provided in the facilities, include a statement to that effect.

3. The health and safety standards included must be provider specific. Explain how the standards will assure recipients' health and safety.

4. Proposed or draft standards are not acceptable.

5. Provide a description of how you will implement and monitor the enforcement of the health and safety standards. You are required to include the results of such monitoring efforts as part of your required annual report (Form HCFA-372).

6. Indicate if you have licensure or certification requirements for any services (or for individuals who furnish these services) provided under the waiver. If so, explain to which providers or individuals they apply.

7. FFP is not available for waiver services furnished by providers who are not in compliance with the standards approved as part of a waiver for the period in which the provider is noncompliant.

NOTE: Provider standards are the criteria which a provider must meet in order to provide waiver services. In order for the standards to be adequate, they must describe the qualities and/or characteristics which assure the provider's capability to perform the service in a safe and effective manner, e.g., training, education, experience, professional credentials, licensing and/or certification or physical plant. Providers may not be required to furnish services statewide since this is unnecessary to assure services are performed in a safe and effective manner.

4442.5 Evaluations - Assurances and Documentation.--

A. Assurance.--Include the assurance that the agency will provide for an evaluation (and periodic reevaluations) of the need for the level of care provided in a hospital, NF, or ICF/MR, as defined by 42 CFR 440.10, §1919(a) of the Act, and 42 CFR 440.150, respectively, when there is a reasonable indication that individuals might need such services in the near future but for the availability of home and community-based services.

NOTE: Evaluation means the review of a client's condition to determine whether he/she requires the level of care provided in a hospital, NF, or ICF/MR as defined by 42 CFR 440.10, §1919(a) of the Act, and 42 CFR 440.150, respectively, and, therefore whether he/she may participate in the waiver. Periodic reevaluations mean a review, at least annually, to determine a recipient's continued need for the level of care described above.

B. Documentation.--

1. If used, describe the factors in addition to the hospital, NF, and ICF/MR level of care requirements as part of your client evaluation and reevaluation process.

2. Include a copy of the written evaluation and reevaluation instrument used to determine the level of care and describe how the evaluations and reevaluations will be made.

3. Describe the party or parties responsible for the evaluation and reevaluation, their qualifications, the factors they will use to evaluate and reevaluate the recipient's need for a hospital, NF, or ICF/MR level of care, and when evaluations and reevaluations will be made. This includes the criteria used to determine level of care.

4. The evaluation and reevaluation instrument must be final. Drafts or proposed instruments are not acceptable.

5. Indicate whether the evaluation and reevaluation instrument and process is identical to that used for hospital, NF, or ICF/MR admissions. If it differs, explain how and why it differs and provide an assurance that the outcome of the new evaluation/reevaluation form is reliable, valid, and fully comparable to the form used for hospital, NF, or ICF/MR placement.

6. Include the agency's procedure to ensure the maintenance of written documentation on all evaluations and reevaluations and the procedure to ensure reevaluations of need at regular intervals. Include an explanation of how, where, and for how long you will maintain written documentation of all evaluations and reevaluations. (In accordance with 45 CFR Part 74, Subpart D, written documentation of all evaluations and reevaluations must be maintained, at a minimum, 3 years from the submission of each Form HCFA-372.)

7. Indicate that the cost of the client evaluation will not be considered a cost reimbursable under the waiver unless, and until, the recipient is receiving waiver services. Costs associated with nonwaiver eligibles may not be claimed or reported as waiver service costs. Such costs, however, may be claimed as administrative costs as activities necessary for the proper and efficient administration of the State plan.

4442.6 Plan of Care.--Explain in detail how the statutory requirements (§1915(c)(1) and (4)) for an individual written plan of care will be met:

o Include in the plan of care an assessment of the individual to determine the services needed to prevent institutionalization.

NOTE: The term "assessment" means an examination of an individual who has been determined (through an evaluation) to meet the level of care requirements for participation in a waiver, to determine what waiver services are needed to prevent institutionalization or whether waiver services constitute an acceptable alternative to institutional care.

o Describe the content of the plan of care and make clear that it includes the medical and other services to be given, their frequency, and the type of provider to furnish them.

NOTE: FFP is not available for waiver services which are furnished without a written plan of care.

o Include in the waiver request a description of the qualifications of the individuals who will be responsible for developing the individual plan of care and specify the type of provider that will develop the plan of care.

o Indicate in the waiver request that the written plan of care is subject to approval by the Medicaid agency and specify the extent to which you will review plans of care.

o Effective April 7, 1986, the State agency administering the Medicaid plan may, whenever appropriate, enter into cooperative arrangements with the State agency responsible for administering the program for children with special health care needs under title V, the Maternal and Child Health Block Grant, in order to assure improved access to coordinated services to meet their needs.

4442.7 Freedom of Choice - Assurances and Documentation.--

A. Assurance.--Include the assurance that when a recipient is determined to be likely to require the level of care provided in a hospital, NF, or ICF/MR, the recipient or his or her legal representative will be:

o Informed of any feasible alternatives available under the waiver; and

o Given the choice of either institutional or home and community-based services.

NOTE: Feasible alternatives may only be determined after the assessment of an individual's care needs and an evaluation of level of care. Thus, it is not expected that a client will be offered waiver services if the assessment indicates he or she cannot be adequately served in the community.

B. Documentation.--Provide a description of the agency's plan for informing eligible recipients of the feasible alternatives available under the waiver and allowing recipients to choose either institutional services or home and community-based services as part of the waiver request. Include how the client's free choice will be documented.

State in the waiver request that the agency will provide an opportunity for a fair hearing under 42 CFR Part 431, Subpart E, to beneficiaries who are not given the choice of home and community-based services as an alternative to hospital, NF, or ICF/MR services, or who are denied the service or provider of their choice.

4442.8 Cost Effectiveness - Assurances and Documentation.--

A. In your request, assure that:

1. The average per capita fiscal year expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made in that fiscal year for the level of care provided in a hospital, NF, or ICF/MR under the State plan had the waiver not been granted.

a. These expenditures must be reasonably estimated and documented by the agency; and

b. The estimates must be annualized and cover each year of the waiver period.

c. In making estimates for a waiver that applies only to individuals with a particular illness (e.g., AIDS) or condition (e.g., chronic mental illness) who are inpatients of, or who would require the level of care provided in, a hospital, NF, or ICF/MR, you may estimate the average per capita expenditures for such individuals without including expenditures of other individuals who are inpatients of applicable hospitals, NFs, or ICFs/MR.

d. Effective December 22, 1987, when making estimates for a waiver that applies only to individuals with developmental disabilities who are inpatients of a NF but have been determined, on the basis of your evaluation, to need an ICF/MR level of care, you may estimate the average per capita expenditures that would have been made in a waiver year for those individuals under the State plan based on the average per capita expenditures for inpatients of an ICF/MR without regard to the availability of beds for such inpatients.

NOTE: The fiscal year of a waiver program starts with the effective date of the waiver and ends 12 months later.

2. The agency's actual total expenditures for home and community-based and other Medicaid services provided to individuals under the waiver will not, in any year of the waiver period, exceed the amount that would be incurred by Medicaid for these individuals in a hospital, NF, or ICF/MR in the absence of a waiver.

B. General Documentation.--

1. Estimates of average per capita expenditures must cover each year of the term of the waiver.

2. All formula factors must be labeled, formulas worked to solution, and the arithmetic must be correct.

3. The cost per unduplicated recipient determined using the formula must be less with the waiver than without the waiver or both per recipient costs must be equal. In waivers estimating little or no cost savings, describe the fiscal controls to be put in place to preclude expenditures which would exceed institutional costs.

4. Provide a formula for each level of care and in the aggregate. For example, a request proposing to deinstitutionalize residents of both hospitals and NFs must include three formulas for each year of the waiver: one for hospital recipients, one for NF recipients, and one in the aggregate.

5. The estimates must be reasonable, based on statistically sound and valid procedures, and verifiable. Present your data on the basis of the average cost per unduplicated recipient.

Unduplicated recipients refers to the total number of recipients receiving services referred to in each of the formula elements of the simplified formula. You need to know this number in order to compute the average per capita cost for each of the formula elements. An "unduplicated" recipient is only counted once for purposes of determining the average per capita cost for each formula element. Thus, when an individual is served under any single formula value category on multiple occasions during the year, he or she is counted as one unduplicated recipient in the applicable

single formula value category. For example, a recipient who receives waiver services during the waiver year and leaves the waiver but returns to the waiver in the same waiver year is counted as one recipient for purposes of determining formula values C, D, and D' in that waiver year.

6. In developing the average per capita cost estimates, use actual data on costs as reflected in your most recent Form HCFA-2082. Waivers that are targeted to individuals with a particular illness or condition are exempted from this requirement and instead you must document actual costs for the target population. Explain any discrepancies with the Form HCFA-2082. Resolve discrepancies due to erroneous Form HCFA-2082 reports by submitting a revised Form HCFA-2082 prior to approval of the waiver proposal to:

Office of Medicare and Medicaid Cost Estimates
Office of the Actuary
N3-26-00
7500 Security Boulevard
Baltimore, MD 21244-1850

NOTE: For renewals, HCFA compares the average per capita cost figures to the most recent Form HCFA-372 or HCFA-372(S) data. For renewal requests that do not have average per capita cost figures for the appropriate institutional level of care in its Form HCFA-372 or HCFA-372(S), you will need to document thoroughly your basis for your estimates of the average per capita cost of the appropriate institutional level of care.

7. In estimating cost and utilization for home and community-based services, use actual data for the most recent year before the waiver takes effect when such data is available. Also, provide the assumptions on which estimated utilization is based and the source of research supporting those assumptions (e.g., demonstration studies, etc.). Similarly, cost out each service to be provided, including the unit cost of each service and the projected utilization of each service. Furnish all assumptions driving such cost/utilization estimates and the source of any data or research supporting those assumptions.

8. OBRA 1990 permits you to estimate your average per capita institutional expenditures in waivers that apply to individuals with mental retardation or a related condition and who reside in an ICF/MR at the time it is terminated, by determining the average per capita expenditures that would have been made in a FY for these individuals without regard to any such terminations. You may use the ICF/MR costs that would have been incurred in these terminated facilities. This provision applies as if included in the enactment of OBRA 1981 but applies only to facilities decertified on or after November 5, 1990.

9. Do not provide data for institutional groups not included in the waiver.

C. Cost Effectiveness Formula.--Demonstrate the cost effectiveness or cost neutrality of the requested waiver by satisfying the following equation:

$$D + D' \leq G + G'$$

For the equation to be considered acceptable, the factor values have to meet the requirements and definitions indicated below.

NOTE: If any of the following requirements are not met, the differences must be fully explained and documented. All average per capita cost estimates must be based on statewide data except in waivers that apply only to individuals with a particular illness or condition who are inpatients of, or would require the level of care provided in, a hospital, NF, or ICF/MR. In the latter case, the average per capita costs may be based on the specific costs attributable to the involved clients.

For waivers that apply only to individuals with a particular illness or condition and who are inpatients of, or would require the level of care provided in, hospitals, NFs, or ICFs/MR, you are not required to use the entire patient population. The estimates may be based on only the number of such inpatients of the hospitals, NFs, or ICFs/MR, who are comparable to the waiver group but not expected to be included in the waiver program. Provide detailed documentation describing how the data for the group were derived.

1. C Value.--The C value reflects the estimated annual unduplicated number of individuals who are expected to receive home and community-based services under the waiver. Although factor C is not a part of the revised cost neutrality formula, you are required to indicate the number of unduplicated waiver individuals you intend to serve in each year of the waiver program. You must anticipate that individuals may leave the waiver program during the course of any waiver year. Therefore, estimates of the C value must include an adjustment to reflect both phase in and phase out of particular clients throughout each waiver year. Although it may be useful for you to conceptualize your waiver population in full year equivalents or waiver slots, the C value submitted must be adjusted to reflect an unduplicated recipient count which incorporates clients turnover expectations.

The C value constitutes a limit on the size of the waiver program. This number may be revised through an amendment request when you determine that you need to increase or decrease the number of individuals you estimate you will serve under the waiver.

2. D Value.--The D value must equal the estimated annual average per capita Medicaid cost for home and community-based services for individuals in the waiver program. For the D value to be acceptable:

a. The D value must be broken out into unit cost and utilization components, both of which must be fully explained and documented. Also, identify the unit, e.g., day, hour, month, trip, etc. All estimates must reflect whole numbers of persons and services, fractions of persons or services are unacceptable.

b. The cost component must include a cost per unit of service for each service rendered. The cost per unit must be reasonably estimated. (See §4441.3 regarding the room and board component of services provided by live in caregivers.)

Any increase projected in the unit cost per service must be demonstrated to not exceed the Medical Consumer Price Index unless a higher rate can be justified.

c. The utilization component to be applied to unit cost must include a utilization rate for each individual type of service. The utilization rate must be reasonably estimated based on a comparable population. In waiver renewal requests, HCFA expects utilization trends established during the waiver to be documented and continue through the renewal period.

d. If bundling of services is authorized, you must document the cost and utilization of each component service that makes up the bundled service to support the final cost and utilization of the bundled service used in the cost effectiveness or cost neutrality formula.

e. For each service, multiply the unit cost times the utilization rate to derive the service cost per recipient. (See NOTE.)

f. Multiply the service cost per recipient by the number of recipients expected to need each type of service to obtain an overall cost per service.

g. Add together the overall cost per service for all services to obtain an overall cost for waiver services.

h. Divide the overall cost of waiver services by the C value as defined in subsection C.1. to obtain the D value. (C X D) equals the overall cost of waiver services in step g.

i. The following is an example of how the derivation of the D value may be displayed:

Waiver Services	Unit Cost	No. of Recipients Receiving Services	Average Units Per Recipient (Adjusted for Client Turnover/ Average Length of Stay)	Total Cost

NOTE: The D value in the cost effectiveness/neutrality formula must take into account the expected phase in and phase out of unduplicated recipients throughout each waiver year in order to reasonably estimate the per capita cost of waiver services.

3. D'Value.--The D' value must equal the estimated annual average per capita Medicaid cost for all services other than waiver services that are provided to individuals in the waiver program including expanded EPSDT services and institutional costs when a person leaves the waiver for institutionalization and returns to the waiver in the same waiver year. If you include a waiver service that is also covered under the State plan and define the service identically except for utilization limits, the State plan services, up to the imposed limit, would be included under D'. The

services provided under the waiver that exceed the State plan utilization limits would be included under factor D as waiver costs. The D' factor also includes all State plan services that are provided to individuals while they are also receiving waiver services. For the D' value to be acceptable:

a. An explanation with supporting documentation of how the D' value was derived must be provided.

b. The D' value must equal or exceed the G' value as defined in §4442.8. Where the D' value is less than the G' value, the difference must be fully explained and documented.

4. G Value.--The G value must equal the estimated annual average per capita Medicaid cost for hospital, NF, or ICF/MR care that would be incurred for individuals served in the waiver, were the waiver not granted. For the G value to be acceptable:

a. The G value must be reasonably related to the total cost for the level of care (from the Form HCFA-2082) divided by the annual number of unduplicated recipients. For waivers that apply only to individuals with a particular illness or condition, you may use estimates based only on that particular group. You must provide an explanation with supporting documentation of how the value was derived.

b. The projected first year G value must not deviate substantially from previous year trends. Any inflation adjustment must be no greater than the current Medical Consumer Price Index (MCPI) unless a higher rate is fully justified by the State.

NOTE: See §4442.8.B.8 regarding the inclusion of costs of terminated ICF/MR beds.

5. G' Value.--The G' value must equal the estimated annual average per capita Medicaid costs for all services other than those included in factor G for individuals served in the waiver, were the waiver not granted. The G' value includes expanded EPSDT services that are not accounted for in the G value. For the G' value to be acceptable:

a. An explanation with supporting documentation of how the G' value was derived must be provided.

b. The G' value must be less than or equal to the D' value as defined in §4442.8 unless fully explained and documented.

c. In situations where a waiver will provide services to individuals who although requiring a NF level of care are hospitalized because NF placement is not possible, the actual cost of caring for these individuals in a hospital should be shown in this value. Therefore, in this situation, the G' value would be the weighted average of all other State plan services not included in factor G.

6. Computation of Expenditures for Individuals With a Particular Illness or Condition.--For a waiver that applies only to individuals with a particular illness or condition who are inpatients of, or require the level of care provided in, hospitals, NFs, or ICFs/MR, you may determine the average per capita expenditures that would have been made in a waiver year for these individuals under the State plan separately from the expenditures for other individuals in the affected hospitals, NFs, or ICFs/MR. That is, for waivers directed at any specified group, you may make expenditure estimates specific to that group of patients who are inpatients of Medicaid certified hospitals, NFs, or ICFs/MR distinguished by illness or condition, regardless of the costs for those inpatients in the respective certified facilities. While this method may be used, you are not precluded from using the usual method of estimating average per capita expenditures, e.g., include the cost of all Medicaid recipients. AIDS or AIDS related conditions are examples of a particular illness or diagnosis, while chronic mental illness or ventilator dependency are considered examples of conditions.

This provision applies to current inpatients of Medicaid certified facilities and is effective for new waivers and renewals of waivers approved on or after October 21, 1986. Previously, under the authority of §9502(d) of COBRA (P.L. 99-272), the use of other than statewide data was restricted to the physically disabled and was effective for services furnished on or after August 13, 1981. The COBRA provision was superseded by §9411(a)(3) of OBRA 1986 (P.L. 99-509) which expanded the authority to use less than statewide data for individuals with a particular illness or condition who are deinstitutionalized. Section 8437 of the Technical and Miscellaneous Revenue Act of 1988 (P.L. 99-5009) further expanded the OBRA 1986 provision by clarifying that less than statewide data may be used for waivers serving individuals with a particular illness or condition who are inpatients in or who would require the level of care in a hospital, NF, or ICF/MR. This provision is effective for waiver applications submitted before, on, or after November 10, 1988, the date of enactment of the Technical and Miscellaneous Revenue Act of 1988.

7. Effect of the Preadmission Screening Requirement on Cost Estimates.--For waivers serving individuals with mental retardation or a related condition, you may revise your per capita cost estimates to take into account increases in ICF/MR costs resulting from implementation of the preadmission screening requirement. It is expected that increased costs resulting from the preadmission screening requirement affect your estimate of formula value G. This provision is effective for expenditures made on or after January 1, 1989. Any revisions to your per capita expenditure estimates for this purpose must be made through the usual amendment process.

4442.9 Annual Report - Assurance and Documentation.--

A. Assurance.--Include the assurance that annually the agency will provide HCFA with information on the waiver's impact. The information must be consistent with a data collection plan designed by HCFA (currently Forms HCFA 372 and/or 372(S)) and must address the waiver's impact on:

1. The type, amount, and cost of services provided under the State plan; and

2. The health and welfare of recipients.

B. Forms HCFA-372 or 372(S).--The first year Form HCFA 372 or Form HCFA 372(S) report must be submitted on or before the 18th month after the effective date of the waiver. Subsequent reports for years 2 through 5, as applicable, are due on or before 6 months after each anniversary date (the 30th, 42nd, 54th and 66th month, respectively, after the effective date of the waiver).

C. Documentation.--Describe your system for collecting the information needed to complete required HCFA reports.

4442.10 Financial Accountability - Assurance and Documentation.--

A. Assurance.--Include the assurance that there will be financial accountability for funds expended for home and community-based services, provision will be made for an independent audit of your waiver program (except as HCFA may otherwise specify for particular waivers), and that you will maintain and make available to HHS, the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver, including reports of any independent audits conducted.

B. Documentation.--

1. Accountability.--

a. Assure HCFA that you will maintain and require providers of these services to maintain financial accountability for funds expended for these services.

b. The Medicaid State Agency is directly accountable for expenditures made for Medicaid home and community-based waiver services irrespective of the involvement of any other State agencies in the administration of the waiver or the provision of waiver services. Where the administration of a waiver depends on agreements between State agencies, copies of those agreements must be submitted with the request for a waiver. The absence of an agreement needed to document the satisfaction of a required assurance may be considered by HCFA to be equivalent to the absence of the assurance.

c. Describe the records and information that will be maintained to support financial accountability and inform HCFA how you will meet the requirement. In accordance with 45 CFR Part 74, Subpart D, records and information to support financial accountability must be maintained, at a minimum, 3 years from the submission of each Form HCFA-372 or HCFA-372(S) report. Explain how these records will ensure that there is an audit trail for all State and Federal funds. The audit trail must begin at the point of service to the beneficiary and follow through to the claim for FFP.

d. Use the Medicaid Management Information System (MMIS) to track the costs of waiver services. If you do not have a MMIS, provide a detailed description of the audit trail.

e. Indicate that providers will be advised of their accountability for funds.

2. Independent Audit.--If you conduct an audit under the provisions of the Single Audit Act of 1984 (P.L. 98-502), the completion of such an audit will be deemed to satisfy the independent audit requirement. If you do not conduct an audit under the Single Audit Act, the following applies.

a. HCFA may exempt you from meeting this requirement if you request it and justify the basis for the exception; for example, by demonstrating that the cost of the audit would exceed the potential savings that would accrue from the waiver program. Documentation must include a statement of the proposed cost as provided (and signed) by the organization who would perform the audit and a description of the relationship of that organization to the Medicaid State Agency (MSA).

b. In order to meet the independent audit requirement contained in 42 CFR 441.302(b), the audit must be performed by an independent auditor. An "independent auditor," as defined in section 5.f. of OMB Circular A-128 Audits of State and Local Governments, means:

(1) A State or local government auditor who meets the independence standards specified in generally accepted government auditing standards, as defined in Chapter IV. B. of the Standards for Audit of Government Organizations, Programs, Activities, and Functions, developed by the Comptroller General, dated February 27, 1981; or

(2) A public accountant who meets such independence standards.

The waiver request or renewal request must indicate whether the audit will be performed by an entity outside of State government. If it is not to be performed by an outside entity, the request must indicate who would perform it, provide a description of how the entity related to the MSA, its umbrella agency and any other State agency with any responsibility for the waiver, and indicate to whom the entity reports within State government.

c. The auditors must verify that:

(1) Only allowable home and community-based services waiver expenditures under an approved waiver are being claimed for FFP on the Form HCFA-64.

(2) You are correctly reporting all your home and community-based services waiver expenditures on the Form HCFA-64.

d. The audit must be made in accordance with standards for governmental auditing, applicable Federal statutes, regulations, and policy issuances, and your approved home and community-based services waiver. It must also include tests of the accounting records and other auditing procedures as deemed necessary. At a minimum, the audit must cover the following:

(1) Your system for reimbursing home and community-based waiver services, especially the procedures employed in accumulating expenditures for the purpose of preparing the Form HCFA-64. This includes a test of either all claims or a sample of claims made on the Form HCFA-64 to the source documentation and a verification that you are maintaining all records, information, and supporting documentation to assure financial accountability in accordance with 42 CFR 441.301(b).

(2) Home and community-based services providers, including a verification that the reimbursement rates were established and adjustments made in accordance with the approved methodology, that services were actually provided and billings are specific to eligible recipients, that the services were actually reimbursed at the appropriate rate for the correct number of days and in accordance with the provider agreement, and that documentation exists to support all of these items. HCFA expects the auditors to make on site visits to the providers.

(3) The eligibility of your home and community-based services recipients, including a verification that eligibility has been established as of the effective date of the waiver and that eligibility is supported by care record documentation. In conjunction with the verification of provider billings, ensure that the recipient's case record supports services provided and billed.

(4) Your home and community-based services waiver reporting on the Form HCFA-64, including a verification of the information reported on the Forms HCFA 64.9 and 64.9p, Line 1.R., and a verification that all waiver costs have been reported as such in those two sections (as opposed to being claimed elsewhere on the Form HCFA-64).

e. The final audit report is generally structured as follows:

- o Background,
- o Purpose and Scope,
- o Findings,
- o Conclusions,
- o Recommendations, and
- o Supporting Attachments/Appendices.

f. The independent audit must cover the period up to the final year of the waiver and must be completed and made available to HCFA no later than 90 days before the expiration of the waiver.

You may have each waiver year audited separately or may have several years combined into one audit.

When a waiver expires or is terminated, the independent audit of all payments made under the waiver is due within one year after the date of termination.

Submit copies of the final audit report to:

- o Associate Regional Administrator, Division of Medicaid, HCFA, and
- o Director, Medicaid Bureau, HCFA

| 4442.11 Independent Assessment of the Waiver.--Indicate whether you will provide for an independent assessment of the waiver that evaluates the quality of care provided, access to care, and cost effectiveness of the waiver.

For the assessment to be considered independent, it may be performed by an outside contractor, university, or other entity outside of the State government. It may also be performed by another entity within the State government that is not responsible to the Medicaid State agency or the agency responsible for administering the waiver program (including another administrative part of an umbrella agency in the State of which the Medicaid agency or the agency administering the waiver is also a part.)

For example, a State which has an audit or assessment office that does not report to the MSA or any other agency with any responsibility for the waiver may perform an independent assessment even if that audit or assessment office reports to the umbrella agency incorporating the MSA.

The request must indicate the organization to perform the assessment and describe its relationship to the State. The waiver request or renewal request must indicate whether the assessment is to be performed by an entity outside of State government. If it is not to be performed by an outside entity, the require must indicate the entity to perform it, provide a description of how the entity relates to the MSA and any other State agency with any responsibility for the waiver, and indicate to whom the entity reports within State government.

The results of the assessment must be submitted to HCFA at least 90 days prior to the expiration of the approved waiver period and must cover the period up to the final year of the waiver.

Submit copies of the final assessment report to:

- o Associate Regional Administrator, Division of Medicaid, HCFA, and
- o Director, Medicaid Bureau, HCFA

The assessment should verify that:

- o The waiver is cost effective/neutral for each year of its existence. For example, you may include a valid statistical sampling of recipients under the waiver to assess the need for inpatient services in a hospital, NF, or ICF/MR or to ensure that without the waiver there is medical evidence to support institutionalization. Through this sampling, verify that recipients are given proper information as to their choice of institutional services or home and community-based services.
- o Necessary safeguards are in place to ensure the health and safety of the recipient. For example, you may include a verification of a valid statistical sample of providers in the assessment and a further verification of quality of care furnished to the recipient population.
- o Individuals receiving waiver services are in fact Medicaid eligible.
- o The appropriate target groups are being properly claimed in accordance with the law and regulations.

4443. HOME AND COMMUNITY-BASED SERVICES - MODEL WAIVER REQUEST

A. Background.--Under the authority of OBRA 1981 (P.L. 97-35) and amended by P.L. 99-272, COBRA, P.L. 99-509, OBRA 1986, P.L. 100-203, OBRA 1987, P.L. 100-360, the Medicare Catastrophic Coverage Act of 1988, P.L. 100-647, the Technical and Miscellaneous Revenue Act

of 1980 and P.L. 101-508, OBRA 1990, you can offer, through a Secretarial waiver, home and community-based services to individuals who otherwise would require institutionalization. Interim final regulations implementing these provisions were published in the Federal Register on October 1, 1981. Final regulations were published in the Federal Register on March 13, 1985, which amended the interim rules. A notice of proposed rule was published on June 1, 1988 and a final rule with comment period was published on July 25, 1994 which incorporated the legislation noted above and comments received as a result of the notice of proposed rule. Further, §1902(a)(10)(A)(ii)(VI) of the Act, as added by §137(b)(7) of TEFRA 1982, permits coverage as optional categorically needy for the individuals who will receive home and community-based services under the waiver, and who, if they did not receive home and community-based services, would require institutional care. For example, if an individual would qualify for Medicaid in the institutional setting because the income of the parents or of a spouse was not deemed available to the individual, you may elect this optional coverage group and apply these same deeming rules when determining eligibility for home and community-based services. This option allows you to eliminate situations where individuals must remain institutionalized to retain Medicaid eligibility even though the recipient could receive the necessary services at home and at a lower cost to Medicaid.

Section 4118 of OBRA 1987 amended §1915(c)(3) of the Act to provide for a waiver of the community income and resource requirements for the medically needy, as specified in §1902(a)(10)(C)(i)(III) of the Act. Reinstatement of this waiver is retroactive to waivers or renewals approved on or after October 21, 1986.

Waiving of the community income and resource requirements for the medically needy allows individuals who might not otherwise qualify for Medicaid under community rules to qualify. For example, by waiving the requirements specified at §1902(a)(10)(C)(i)(III) of the Act, income is not deemed from parent to child or spouse to spouse, or States may apply the spousal impoverishment eligibility rules.

You may wish to request a waiver of the community income and resource requirements for the medically needy, as specified at §1902(a)(10)(C)(i)(III).

B. Model Waiver Request.--To assist you in utilizing the home and community-based waiver process to avoid unnecessary institutionalization and to reduce expenses, a model waiver request (see Exhibit A) can be submitted in addition to or in lieu of a regular home and community-based waiver services request. You are required to offer at least one home and community-based service under the model request, e.g., case management services. You must meet all statutory and regulatory requirements for waivers that were published in the Federal Register on October 1, 1981, and as amended on March 13, 1985, June 1, 1988, and July 25, 1994.

Prior to April 7, 1986, you were limited to a total of up to 50 cases for each model request. The term "cases" in this context was defined as 50 unduplicated recipients per waiver year. Effective April 7, 1986 through December 21, 1987, the model waiver was limited to 50 individual

participants in the waiver at any one time. Effective December 22, 1987, model waivers may contain up to 200 individuals at any one time. However, you are not required to serve 200 persons under a model waiver. Individuals who leave the waiver may be replaced throughout the waiver year. In submitting estimates for a model waiver request, adjust your value of C to reflect the expected turnover during each waiver year. Therefore, the C value of model waivers may be greater than 200 unduplicated recipients to accommodate the replacement of individuals who leave the waiver program. Model waivers previously approved to serve 50 individuals however, must be amended should you wish to serve more individuals than were originally approved.

If you wish to use waivers to cover larger numbers of recipients or to provide a comprehensive range of services, utilize the regular waiver system or submit another model request. This separation between model waiver requests and other waiver requests will enable us to process both types of requests more efficiently. See §§4440ff for more detailed information about the waiver requirements and the regular waiver system.

C. Instructions for Completing a Model Waiver Request.--Many of the items in the model waiver request (see Exhibit A) do not need further information from you and are required by the statute or regulations. The State official's signature on the request indicates your agreement and acceptance of the particular item.

Heading. Enter the name of the State.

Item 1. No information required.

Item 2. In order to obtain approval of your model waiver request, provide to recipients under the waiver at least one home and community-based service, e.g, case management services. You may also request approval under the model waiver request to provide other home and community-based services; however, the addition of such services will necessitate additional documentation.

Approval to provide one or more of the following services may be requested:

- o Case management services;
- o Homemaker services;
- o Home health aide services;
- o Personal care services;
- o Adult day health services;
- o Habilitation services;
- o Respite care services;
- o Day treatment or other partial hospitalization services, psychosocial rehabilitation services and clinic services (whether or not furnished in a facility) for individuals with chronic mental illness; and

o Other services requested by the Medicaid agency and approved by HCFA as cost effective and necessary to avoid institutionalization.

Attach a complete description and definition of each service to the model waiver request that you propose to offer. See §4442.3 for additional information about these requirements.

Home and community-based services waivers allow you to provide as medical assistance, services not included in the definition of "medical assistance" in §1905(a) of the Act. However, it must be demonstrated that the provision of such services will enable you to serve recipients more cost effectively outside of a hospital, NF, or ICF/MR (whose costs would otherwise be reimbursed under the State plan). Therefore, the services proposed to be provided in the waiver must not duplicate services which are provided under your State Medicaid plan. However, you may provide services under a waiver similar to those provided under the State plan where they are defined differently under the waiver or which differ in amount, duration or scope from those provided in the State plan.

Item 3. Check the categories you wish to include under the waiver: categorically needy, optional categorically needy, or medically needy. Also check which applicable target groups you wish to include.

You may include in a model waiver blind or disabled individuals who are eligible under the special home and community-based waiver eligibility group included in 42 CFR 435.217. The special home and community-based waiver eligibility group specified under 42 CFR 435.217 is made up of individuals who would be eligible for Medicaid if they were in an institution, who have been determined to need home and community-based services in order to remain in the community, and who are covered under the terms of the waiver. If you include individuals eligible under the special home and community-based waiver eligibility group in a waiver request, it must also provide information on the post-eligibility treatment of income and resources of those individuals receiving home and community-based services furnished under a waiver. Information on post-eligibility treatment of income and resources must follow regulations at 42 CFR 435.726 for non-209(b) States and regulations at 42 CFR 435.735 for 209(b) States and §1924 of the Social Security Act for an individual with a community spouse.

NOTE: Section 9502(e) of COBRA and §9435(a) of OBRA 86, which apply to waivers or waiver renewals approved before, on, or after April 7, 1986, provide that you may set your own maintenance needs deduction amounts for individuals without regard to the limits imposed by regulations at 42 CFR 435.726(c)(1) and 42 CFR 435.735(c)(1). You must establish a maximum maintenance needs deduction amount which will not be exceeded for any individual under the waiver, and the maintenance needs deduction amount must be based on a reasonable assessment of the individual's needs. Except for these restrictions, you may establish the deduction amount for individuals at any level you choose. You may also establish different deduction amounts for different individuals, or groups of individuals, based on an assessment of each individual's or group's particular needs.

The upper limits for maintenance needs deduction amounts already established in regulations for spouses and dependent children continue to apply. However, as with the deduction amount for individuals described above, you may establish the deduction amount for a spouse or dependent children based on an assessment of each spouse's or family's needs. (See §3590.9.)

Pending publication of final regulations, spousal impoverishment eligibility rules, specified at §1924 of the Act, may be used for individuals with a community spouse (whose eligibility is determined under 42 CFR 435.217).

States have an option concerning the application of the post-eligibility rules for individuals with a community spouse. States may use either the spousal impoverishment post-eligibility rules specified at §1924 of the Act or the post-eligibility rules specified at 42 CFR 435.726. (Spousal impoverishment post-eligibility rules can be used only if the State is using the spousal impoverishment eligibility rules.)

The spousal impoverishment post-eligibility rules provide for a more generous community spouse and family allowance than the rules under 42 CFR 435.726 and 42 CFR 435.735. The spousal protection rules also provide for some personal needs allowance (PNA) described in §1902(q)(1) of the Act for the needs of the institutionalized individual. This allowance is a "reasonable amount for clothing and other personal needs of the individual...while in an institution." For an institutionalized individual, this can be as low as $30 per month. Unlike the institutionalized individual whose room and board are covered under Medicaid, the personal needs allowance of the home and community-based waiver recipient must include a reasonable amount for food and shelter as well as for clothing. The $30 monthly PNA is not a sufficient amount for these needs when the waiver recipient is living in the community.

Therefore, States which elect to treat home and community-based services waiver participants with community spouses under the §1924 spousal rules must use as the individual's personal needs allowance either the maintenance amount which the State has elected under 42 CFR 435.726 or 42 CFR 435.735, or an amount that the State can demonstrate is a reasonable amount to cover the costs of the individual's maintenance needs in the community.

You may wish to provide home and community-based services to blind or disabled individuals who are 18 years of age or less under the model waiver request if you do not opt to cover them under §1902(e)(3) of the Act. Under this provision, you have the option of covering disabled children age 18 or under who are living at home and who would be eligible for SSI or a State supplementary payment, and therefore Medicaid, if they were in a medical institution. However, even if you cover such individuals under §1902(e)(3), you may also wish to cover them under the model waiver request to provide home and community-based services which are not otherwise included in the State Medicaid plan. Further, under the model waiver, you may also be granted a waiver of the statewideness requirement under §1902(a)(1) and the comparability requirements under §1902(a)(10)(B) of the Act.

| Item 4. Check yes or no.

| Item 5. Attach a specific description of how the services will differ from those provided under the State plan and provide the criteria which distinguish these from services provided under the State plan in terms of amount, duration and scope of services. Also attach a description of the types of individuals you intend to serve under the waiver and any additional targeting restrictions.

| Item 6. Check yes or no. If yes is checked, show which geographic subdivisions (e.g., counties) will be included.

| Item 7. Attach a description of the qualifications of the individuals who will be responsible for developing a recipient's plan of care. Documentation requirements specified in §4442.6 must also be met.

| Item 8. No information required.

| Item 9. No information required.

| Item 10. Check yes or no. If yes is checked, explain in detail how such determinations will be made and implemented. This description must include the procedure to be used, including how costs will be estimated and compared.

| Item 11. Enter the name of the State.

| Item 11(a). Submit the documentation specified in §4442.4B unless this documentation was submitted to HCFA for a previously approved waiver request. If previous documentation was provided, specifically identify the standards applicable to each provider and where they are located in the previously approved proposal.

| Item 11(b). Submit the documentation specified in §4442.10B. You may be exempt from meeting the independent audit requirement if you request an exemption and document the reasons, e.g., if the cost of the audit exceeds the estimated savings of your waiver program. (See §4442.10B.)

| Item 11(c). Submit the documentation specified in §4442.5B.

| Item 11(d). Submit a description of your plan for informing eligible recipients of the alternatives available under the waiver and allowing recipients to choose either institutional services or home and community-based services. The plan must describe how the client's free choice will be documented.

If you intend to limit in any way the recipient's freedom of choice to participate in the waiver or to choose the provider(s) of service, separately apply to HCFA for a waiver of the freedom of choice provisions authorized under §1915(b) of the Act. Procedures for this application are found in §2100. Otherwise, the requirements of this assurance must be met.

| Item 11(e). Develop an estimate, based on actual cost data, of the average per capita cost of the individual's care in the institution as compared to the cost of that individual's care in the home or community setting. These estimates are to be provided in accordance with the equation specified in 42 CFR 441.303(f). This estimate is to include cost and data for the individuals for whom you will provide home and community-based services. Estimates of hospital or nursing home average

per capita costs must be drawn from actual experience and from the most recent figures entered on the Form HCFA-2082, unless you have an equally reliable source of alternate data. See §4442.8 for additional information about these requirements.

Items 11(f) and 11(g). No further information is needed.

Item 12. If you opt to provide an independent assessment, the assessment must meet the requirements specified in §4442.11.

The heading of the application must include the name of the State and the closing must include the signature, title and date of signature of the appropriate single State agency or State Medicaid official.

Effective for waiver requests received after September 9, 1985, the effective date for a new waiver is established by HCFA prospectively on or after the date of approval and after consultation with you.

EXHIBIT A

MODEL WAIVER REQUEST
Special Targeted Home and Community-Based Services Waiver

State_____

Waiver Title_____

1. A waiver is requested for an initial 3-year period (or 5-year renewal) under §1915(c) of the Social Security Act to provide home and community-based services to individuals who would otherwise require the level of care provided in a hospital, nursing facility, or intermediate care facility for the mentally retarded, the cost of which would be reimbursed under the State Medicaid plan.

2. The State requests that the following home and community-based services be included under this waiver request:

_____

_____

Other home and community-based services (not available under the State plan) which the State proposes to offer are:

_____

_____

A complete description and definition of all home and community-based services to be provided under this waiver is attached. (For waivers which include prevocational, educational and supported employment services as part of habilitation services or which provide day treatment or other partial hospitalization services, psychosocial rehabilitation services and clinic services for individuals which chronic mental illness, see §4442.3 for required assurances.)

3. The sole purpose of this request is to provide authority for the State to furnish the requested services in the home and community setting to no more than 200 individuals at any one time during the waiver who would be Medicaid-eligible if institutionalized. These individuals will be from among the following categories:

(a) Categorically needy ___ Yes ___ No.

(b) Optional categorically needy ___ Yes ___ No.

(c) Medically needy ___ Yes ___ No.

Under authority of §1902(a)(10)(A)(ii)(VI), such individuals would be eligible for Medicaid services even if they would otherwise be ineligible for Medicaid while living at home because of the SSI deeming rules or because of a 209(b) State's deeming rules. Such individuals include:

(d) Blind or disabled children with an ineligible parent(s) where income deemed from the parent(s) would cause the applicant to be ineligible for SSI if the family shared a household; _____ Yes _____ No.

(e) Blind or disabled individuals with an ineligible spouse where income deemed from the spouse would cause the applicant to be ineligible for SSI if the family shared a household; _____ Yes _____ No.

(f) Blind or disabled children with an ineligible parent(s) where income deemed from the parent(s) or the child's own income, up to 300 percent of the SSI payment amount, would cause the applicant to be ineligible for SSI if the family shared a household; and*
_____ Yes _____ No.

*NOTE: If a State elects to cover individuals under 3(d) through 3(h) it must include information on the post-eligibility treatment of income and resources of these individuals in accordance with regulations at 42 CFR 435.726 for individuals in a non-209(b) State and regulations at 42 CFR 435.735 for individuals in a 209(b) State or §1924 of the Social Security Act.

(g) Blind or disabled individuals with an ineligible spouse where income deemed from the spouse or the individual's own income, up to 300 percent of the SSI payment amount, would cause the applicant to be ineligible for SSI if the family share a household.**
_____ Yes _____ No.

(h) Other (specify):_____

4. A waiver of the requirements of §1902(a)(10)(c)(i)(III) of the Act relating to income and resource eligibility rules applicable in the community for the medically needy is requested. _____ Yes _____No.

5. A waiver of the amount, duration, and scope requirements in §1902(a)(10)(B) of the Act is requested. (A description of how the services will differ from the State plan provision and the criteria on which this was based is attached. Also attached is a description of the types of individuals to be served under the waiver and additional targeting restrictions.)

6. A waiver of the statewideness requirements in §1902(a)(1) of the Act is requested.
(a) _____ No.

(b) _____ Yes. Waivers will apply to individuals only in the following geographic subdivisions: _____

7. An individual written plan of care will be developed by qualified individuals for each recipient covered under this waiver. This plan of care will describe the services to be furnished, their frequency, and the type of provider who will furnish them. The plan of care will be subject to the approval of the State Medicaid agency. (A description of the qualifications of the individuals who will be responsible for developing the plan of care is attached.)

**NOTE: If a State elects to cover individuals under 3(d) through 3(h) it must include information on the post-eligibility treatment of income and resources of these individuals in accordance with regulations in 42 CFR 435.726 for individuals in a non-209(b) State and regulations in 42 CFR 435.735 for individuals in a 209(b) State or §1924 of the Social Security Act.

| 8. The services will not be furnished to recipients while they are inpatients of a hospital, NF, or ICF/MR.

| 9. Federal financial participation for services will not be available in expenditures for the cost of room and board of a recipient except when provided as part of respite care in a facility approved by | the State (hospital, NF, foster home, or community residential facility) that is not a private residence.

| 10. The State will refuse to offer home or community-based services to any recipient for whom it can reasonably be expected that the cost of home or community-based services furnished to that recipient would exceed the cost of the level of care provided in a hospital, NF, or ICF/MR. _____ Yes _____ No. (If yes, a description of how this determination will be made and implemented is attached.)

| 11. The _____ Medicaid agency provides the following assurances to HCFA:

(a) Necessary safeguards have been taken to protect the health and welfare of the recipients of the services. (A description of the safeguards is attached.) Those safeguards include:

1. Adequate standards for all types of providers that provide services under the waiver; (a copy of the standards applicable to each provider of service is attached, including, if applicable, standards established for all facilities subject to §1616(e) of the Act);

2. Assurance that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver; and

3. Assurance that all facilities covered by §1616(e) of the Act, in which home and community-based services will be provided, are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.

(b) The agency will assure financial accountability for funds expended for home and community-based services, provide for an independent audit of its waiver program (except as HCFA may otherwise specify for particular waivers), and it will maintain and make available to HHS, the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver, including reports of any independent audits conducted. (A description of the records and information that will be maintained is attached.)

(c) The agency will provide for an evaluation (and periodic reevaluations) of the need for the level of care provided in a hospital, NF, or ICF/MR, as defined by 42 CFR 440.10, §1919(a) of the Act, and 42 CFR 440.150, respectively, when there is a reasonable indication that individuals might need such services in the near future but for the availability of home and community-based services. Written documentation of all evaluations and reevaluations will be maintained. (A description of the agency's plan for such evaluations including the frequency of reevaluation and including record retention procedures as well as a copy of the evaluation instrument is attached.)

(d) When a recipient is determined to be likely to require the level of care provided in a hospital, NF, or ICF/MR, the recipient or his or her legal representative will be:

1. Informed of any feasible alternatives available under the waiver; and

2. Given the choice of either institutional or home and community-based services.

The agency will provide an opportunity for a fair hearing under 42 CFR Part 431, Subpart E, to beneficiaries who are not given the choice of home and community-based services as an alternative to hospital, NF or ICF/MR services or who are denied the service of their choice or the provider of their choice.

(e) The average per capita fiscal year expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made in that fiscal year for the level of care provided in a hospital, NF, or ICF/MR under the State plan had the waiver not been granted. (An explanation with supporting documentation as described in 42 CFR 441.303(f) is attached.)

(f) The agency's actual total expenditures for home and community-based and other Medicaid services provided to individuals under the waiver will not, in any year of the waiver period, exceed the amount that would be incurred by Medicaid for these individuals in a hospital, NF, or ICF/MR, in the absence of a waiver.

(g) The agency will provide HCFA annually with information on the impact of the waiver on the type, amount, and cost of services provided under the State plan and on the health and welfare of recipients. The information will be consistent with a data collection plan designed by HCFA. For purpose of this model waiver, data will be maintained on the cost and utilization of services for each individual.

12. The agency will provide for an independent assessment of the waiver that evaluates the quality of care provided, access to care, and cost effectiveness of the waiver.

Yes _____ No _____

Signature : _____
Title : _____
Date : _____

Attachment(s)

4444. HOME AND COMMUNITY-BASED SERVICES - PROCEDURES TO REQUEST RENEWAL OF APPROVED WAIVERS

A. Background.--Section 1915(c) of the Social Security Act permits you to offer, under a waiver of statutory requirements, an array of home and community-based services that an individual needs to avoid institutionalization. HCFA published a final rule with comment period in the Federal Register on July 25, 1994. This final rule expands coverage of Medicaid home and community-based services under § 1915(c) of the Social Security Act and responds to public comments that were received as a result of the June 1, 1988 publication of a proposed rule. These regulations were codified as 42 CFR 440.180 through 440.250 and 441.301 through 441.310. These regulations allow FFP in the cost of waiver services provided by the State in accordance with the terms of the approved waiver for an initial 3-year period from the waiver effective date. (See §4441E.) Upon your request, the waiver may be renewed for additional 5-year periods.

B. Renewals.--Prior to September 30, 1986, waivers were granted for an initial term of 3 years and, if requested by you and approved by HCFA, were renewed for additional 3-year periods. Effective September 30, 1986, waivers are granted for an initial term of 3 years and, upon your request may be renewed for additional 5-year periods if HCFA's review of the prior waiver period indicates that the assurances you made as a condition of approval have been and continue to be met. In determining whether a waiver may be renewed, HCFA will place great weight on your past waiver performance which is evidenced in part by the assessment conducted by the HCFA regional offices and your correction of any resulting deficiencies. HCFA will also consider the adequacy of the assurances and documentation submitted in support of the renewal request.

C. Instructions for Submitting a Request for a Waiver Renewal.--Waivers which have not been formally renewed by the end of the waiver period automatically expire. HCFA has no obligation to notify you in advance that a waiver's expiration date is nearing nor to formally notify you when expiration occurs. It is therefore suggested that requests for waiver renewals be submitted to HCFA at least 90 days, but no earlier than 180 days, prior to the end of the waiver period. This will allow HCFA sufficient time to review the renewal package and request and review any additional information needed prior to the expiration of the waiver. (See §4441B.)

NOTE: The fact that you are preparing to submit additional information or that additional information submitted is under review by HCFA does not change the expiration date. HCFA must approve, deny, or request additional information on the renewal request within 90 days of receipt, but HCFA is not obligated to complete action before the expiration date if it falls within the 90-day time periods.

If within 90 days of receipt of the renewal request, HCFA is unable to make a finding, based on the information you provided, that the assurances have been met and that the waiver is cost effective or cost neutral, HCFA may either formally request additional information or disapprove the request. (See §4441.D.) For waivers expiring after September 29, 1986, HCFA may, however, in doing so, grant you up to a 90-day extension of the current waiver to permit you the opportunity to more fully document that the statutory and regulatory requirements are met without jeopardizing the continuity of the waiver or to submit a new waiver request. All or part of the temporary extension may be subsumed into the latest approved waiver period.

HCFA will determine whether a request for renewal of an existing waiver is actually a renewal request or a request for a new waiver. If you make significant changes to your waiver program, HCFA will consider it to be a new waiver. On the other hand, minor changes can be included in your renewal request.

When a renewal request is treated as a new request and additional information is requested of you, HCFA may extend your current waiver (those expiring after September 29, 1986) as initially approved for a period of up to 90 days if the current waiver is about to expire. Thus, you would have the opportunity to respond to HCFA's request without jeopardizing the continuity of the current waiver.

If you submit a renewal request after the expiration date of your waiver, the request will be treated as a new waiver request by HCFA.

Effective with waiver requests received after September 9, 1985, the effective date for a waiver will be established by HCFA prospectively on or after the date of approval and after consultation with you. This also applies to renewal requests received after September 9, 1985, which are considered by HCFA to be new requests.

Waiver renewal requests that are considered to be new requests must be limited to one of the following target groups or any subgroup thereof that you may define:

- o Aged or disabled, or both;
- o Mentally retarded or developmentally disabled, or both; or
- o Mentally ill.

As of October 1, 1993, waiver renewals, amendments to renewed waivers, and requests for temporary extensions of existing waivers are to be submitted to your respective regional office.

D. Content of a Waiver Renewal Request.--Requests for waiver renewals must contain the following:

1. A formal request for a renewal of the existing waiver, signed by the appropriate single State Agency or State Medicaid official.